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AUTHOR	Roberts, Bridget; Horwood, Shane; Aunger, Nic; Wong, Michele
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ABSTRACT

Out Doors Inc. is a community-managed mental health organization in Victoria (Australia) that provides psychosocial rehabilitation to adults with mental health needs through outdoor adventure and other recreation experiences. This paper focuses on Out Door Inc.'s Going Places Program. The program, which ranges from 1 day to 4 months, is based on the belief that play, recreation, and outdoor adventure help to integrate mind, emotions, and body and are valuable parts of a holistic approach to personal development and mental health. Participants apply on their own and are not "referred." The 4-month program is a closed group of 12 men and women aged 18 and upwards, broadly fitting the category of being disabled by mental illness. Six levels of increasing challenge accommodate people's generally low levels of fitness and confidence. The focus is on abilities rather than disabilities, with a heavy reliance on the experiential learning model. Participants aim to be more self-sufficient, and the transfer of learning to their daily lives is an important program theme. Going Places makes it clear that it is not part of the medical system; it does not provide "treatment" or "therapy." This helps to ensure psychological safety, since many clients associate the word therapy with compulsory treatment, loss of personal dignity, and the therapist's exertion of power over them. Going Places shares common ground with those who do "adventure therapy" but its position acknowledges one of the main demands of people with mental health needs: that professionals work together to provide continuity of service and choices in a way that respects people as the experts in their own lives. (TD)

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ED 424 079

37

Adventure with Adults Living with Psychiatric Disabilities

By Bridget Roberts , Shane Horwood, Nic Aunger, & Michele Wong

Introduction

The purpose of this paper is to share with you the way we use outdoor adventure in our service for people with psychiatric disabilities. We will explore the boundary area between what we do and the principles and practice of adventure therapy. Our hope is to inspire others in this field to provide our kind of service to people with a psychiatric disability, whose needs have been neglected. This paper will focus on Out Doors Inc.'s Going Places program. We will provide some background information about psychiatric disability in Australia, about our program as a way exploring the boundaries of adventure therapy. In the ten years of Out Doors' existence we have found that outdoor adventure experiences can offer an excellent medium for people's rehabilitation and recovery from psychiatric disability.

About Outdoor Adventure Education

There are a number of central elements of outdoor adventure education that we believe support its use with people with psychiatric disabilities. These elements include:

- It Provides alternative environments, circumstances, activities and opportunities (i.e., a fresh chance for people to succeed at something).
- It can broaden life experiences of people, thereby offsetting a narrowing of experience due to such things as mental illness, social disadvantage and disability.
- It provides experiential learning through active participation in and reflection upon real situations, complementing and/or enhancing more passive approaches to rehabilitation and training, such as discussion, introspection and analysis.
- It is able to challenge a person at the level of their ability, and to build upon the challenge from that point.
- It remains essentially self-directed (a person can choose to climb a rock or not).

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- It has a positive status in society, is attractive and can be structured to ensure success via gradual, supportive and flexible programming.
- It challenges stereotypes and introduces new possibilities for people.
- It provides people with significant positive memories - the building material of peoples' psyches.
- It develops important living skills and abilities such as planning, time management, problem solving, organisation and preparation.
- It provides access to recreation and choices, which is the right of all people.
- We will illustrate how we utilise these elements in our programs.

Background

First we would like to introduce you the people we work with. They are adults of all ages, backgrounds, skills, life experiences and interests. They could be you or your friends or relatives. What they have in common is that they have experienced some form of mental illness or disorder. This experience has affected their ability to function to their full potential and has left them with varying degrees of psychiatric disability (VICSERV, 1995). There is an important difference between mental illness and psychiatric disability, which is very relevant to our view of the use of the term adventure therapy.

People with a psychiatric disability may no longer suffer the symptoms of mental illness, or they may experience episodes. They may be taking medication for their illness and/or seeing a psychiatrist, psychologist or case manager. They all have lasting issues such as:

- low self esteem
- difficulty in forming social relationships
- isolation
- lack of education and training (particularly if mental illness has arisen during teens or early twenties)
- low motivation
- low tolerance to stress
- extremely high levels of fear, confusion and passivity
- the unwanted effects of anti-psychotic medication (such as weight gain and low motivation)
- life on the poverty line
- the social stigma of mental illness

People with a disability seek rehabilitation options, ie services that are made available so that people with a disability may learn to adapt to their world. This in essence describes the word "re-habilitation." Services can include housing, employment, educational, and recreational programs. Out Doors programs operate in this area of disability rather than the area of mental illness.

The needs are widespread and growing for the clients we serve. There has been a shift in mental health policy in Australia and New Zealand, which has meant the closure or scaling down of mental hospitals. The provision of services has been shifted to community based services. Many more people with severe psychiatric disability are living in the community, whether they are in supported housing, with family members or in

independent accommodation. A number of adults with psychiatric disabilities live in rooming houses or homeless shelters and receive few services.

Community based services, both government run and community managed, are many and varied. Services in the state of Victoria are better funded than in other states, but still have a long way to go to meet basic needs. The Burdekin Report, (Human Rights and Equal Opportunity Commission, 1993) reports on the outcome of a major 1993 investigation into human rights and mental illness contains many recommendations which have yet to be addressed fully.

In the last few years the concept of recovery has gained more prominence as an alternative way of viewing psychiatric disabilities. The ideas of recovery have been well promoted by William Anthony, Patricia Deegan and others at Boston University. Recovery does not mean that suffering has disappeared, all symptoms are removed or all functioning completely restored; but rather that recovery is "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles" (Anthony, 1993, p. 11). Patricia Deegan (1988) says that the purpose of rehabilitation programs is not to get people rehabilitated, but rather to "create an environment in which the recovery process can be nurtured like a tender, precious seedling" (p. 11). One part of creating this environment is to offer people a wide variety of rehabilitation programs from which to choose, as each person's journey of recovery is unique. Recognising the value disabled people can offer each other is also necessary in creating this environment.

About Out Doors

Out Doors Inc. is a community-managed mental health organisation, which was formed in 1987 to provide a psychosocial rehabilitation service to adults with mental health needs. We run a range of programs using outdoor adventure and other quality recreation experiences. In the last four years we have received three Mental Health Service Achievement Awards at the Mental Health Services Conference of Australia and New Zealand in recognition of innovative and excellent programs.

Our belief is that play, recreation, and outdoor adventure help to integrate mind, emotions and body and are valuable parts of an holistic approach to personal development and mental health. Our program's philosophy and practice are based on a set of principles for psychosocial rehabilitation first adopted in 1985 in the United States by the International Association of Psychosocial Rehabilitation (Cnaan et al., 1988). These principles can be seen in the reason Out Doors was established in 1987. These purposes include:

- to develop, organise, conduct and evaluate services to improve people's mental health, with particular emphasis on people with a psychiatric disability;
- to use outdoor adventure education as the main vehicle for providing rehabilitation and integration;
- to develop, organise, conduct and evaluate education and training programs for people involved in improving mental health;
- to provide an information, referral, resource and research service;
- to promote the value of outdoor adventure education, recreation, and people's mental health needs.

In the development of our organisation and its services, we attempt to highlight a number of rights often overlooked or not seriously considered when working with people

with psychiatric disability. We pay direct attention to these rights in our planning and programming. These rights include:

- the right to be considered as a person with potential, abilities and a future (not just the right to maintenance and support);
- the right to participate in experiences which our society gives a high value and status (not just what is cheapest and the least trouble;
- the right to adventure (not just the numbing evenness of medication);
- the right to be challenged (not just the right to be protected at all costs).

About the Going Places Program

Going Places program provides opportunities for quality recreation, education, and personal development, which may help each person on his or her path to recovery. The main medium of learning is outdoor adventure. Going Places is a statewide program. It has worked effectively with a great number of both non-government and government mental health services around Victoria, providing support and assistance by running a range of outdoor activities for periods ranging from one day to four months. We tailor activities to the capacities and expectations of the particular group utilising our service. Going Places is also involved with providing information, education and training for all people concerned with improving mental health, including people with a psychiatric disability, their carers, volunteers and paid workers.

The longest Going Places program is a four-month experience, which we have run ten times. Because of its length and intensity this could be considered to have a deeper effect on participants than our shorter programs and thus closest to what some may call therapy. We would like to share the experience of one of our clients on this four-month program. Shane Horwood participated in the program about five years ago and has gone on to contribute to running the organisation and editing the newsletter. He is one of the authors of this paper this is his story of his experience of the program:

> When I look back on my experience with Going Places I think of myself as before and after. Before I was a mess. I was living in a world that didn't make sense to me or anyone else. It was full of doctors' appointments and pills. The doctors could not give me the answers I was looking for and the pills made me feel terrible. It seemed to me there was no way out.
> Then one day I decided to call Out Doors after seeing their poster at the clinic I was going to. I always liked camping and bushwalking so I rang the number. That was my first challenge. The person on the other end was welcoming and positive. Result: happiness.
> My next challenge was to go to information day. I saw slides of people canoeing, abseiling and skiing but they were different from the other people I had met at the clinic. Why? Because they were smiling. Result: sense of wellbeing.
> Then I heard people talk about their experience and how their lives had changed and I thought "Wow!" maybe this could happen to me too. Result: hope.
> My next challenge was to write them a letter about myself. When you've been labelled schizophrenic so many times it's hard to see yourself as more than that. But I wrote the letter anyway. Challenge accepted and completed. Result: happiness

Then came another challenge. Come in for an interview. I was offered tea or coffee and had a chat. Result: feeling of acceptance.
I was accepted by Out Doors onto the four month program and I was accepted by the other participants - some sooner than others but they were doing the same as me. They were getting to know themselves. Result: new awareness and confidence.
With the help of my support person I set goals like surviving an overnight bushwalk and completing the whole four months. Then I set goals like going back to school and getting a job. Confidence came from abseiling a 20-metre wall. I had stared death in the face and won. Later a big achievement was learning to ski. A sense of belonging came in which I could identify myself as "one of the Going Places lot."
My mind had been telling me I was the Devil. A sense of reality and reassurance came from discovering that another participant thought he was God. I knew he was wrong, so we both must have been. We understood each other's experience and helped each other. I realised I was not some crazy person with no future but someone who could set goals and meet them and could function in the community as well as anybody. I could do things. I could have good days as well as bad days.

Program Structure

The four month program is run for a closed group of twelve men and women aged 18 and upwards, broadly fitting the category of being disabled by a mental illness. Selection criteria include that participants are willing to commit to the whole program, can manage their own medication if any, and will choose and work with a trusted support person during and after the program. The gender balance is equal. People find out about us from posters and leaflets or from their case managers, and they apply on their own behalf rather than being "referred."

The four months are structured so that participants attend at least four days a week. Six camps of varying lengths are spread throughout the program, with the level of challenge gradually increasing as we move from lodges or cabins into tents and tarps. We sequence activities gradually and carefully to accommodate people's generally low levels of fitness and confidence. We focus on abilities rather than disabilities and on the acquisition of skills using the experiential learning model. We usually manage to include an introduction to bushwalking, camping, canoeing, whitewater rafting, rock climbing and cross country skiing.

Participants are aiming to be more self-sufficient and to be able to live, work, learn and play with others. Time at our city base is spent on planning and preparation for camps, reviewing and evaluating progress through discussion, active reflection (through, for example, theatre-based activities) and journal writing.

The transfer of learning is an important theme running throughout. We seek to ensure that on selection the participants understand the potential relevance of the program to their lives. We rely heavily on Kolb's model of experiential learning. During the program we work on developing the support person's role. This involves not only supporting the participant through the highs and lows of the program but also assisting with goal setting and, after the program, helping the participant to achieve those goals and move on. We only use public transportation so that participants can learn how to access the outdoors

and adventurous activities independently. Participants are put into contact with relevant community organisations. Finally, we provide three follow-up days, at one, three and six months after the program. Through these methods we seek to help our clients fully integrate their Going Places experience into their lives.

The Role of the Workers

The workers on this program are facilitators and educators who when appropriate take on the role of technical skill instructor. We aim for a forward looking, participant-centred approach. Our background skills in education, recreation, outdoor leadership and community development are complemented by short courses and on-the-job training in working with people with a psychiatric disability. We learn much that is valuable from the feedback that our participants give us.

We make it clear that we are not part of the medical system, we cannot provide "treatment" or "therapy." This helps to ensure psychological safety; people approach us on the level of the contract we have with them. They essentially direct the degree of support or intervention that we provide. For many this in itself is empowering as they often say they cannot talk openly to medical professionals (e.g., occupational therapists and nurses) because they are afraid that any negativity will be seen as a symptom and will lead to an increase in medication. In deeper matters, they are usually clear that we will offer a simple human presence, that we will listen, that we will see them as people not as pathologies and that we will retain hope for them at times when they are losing it. (Watkins, 1996). Participants are also aware of how to obtain medical services when they need them, and we are never more than a day or a mobile phone call away from specialist help.

In none of our literature or public promotions do we describe what we do as therapy or even therapeutic. The First International Adventure Therapy Conference presented us with an opportunity to question and clarify why we have made this choice. In the first place our service is not clinical and we do not employ therapists. We are; however, professionals committed to high quality ethical practices, which are based on sound principles. When we first came to work in the mental health field we would have been quite happy with calling what we did adventure therapy as therapy suggested to us, healing, gentleness, enjoyment, massages, essential oils, spiritual peace, but no more. People we work with who have experienced mental illness associate the word therapy with compulsory treatments, with the loss of personal dignity, with the therapist's exertion of power over them. The therapist is a professional wearing a professional mask, and the person receiving the therapy is labelled as a schizophrenic or whatever their diagnosis is.

We respect therapists, their expertise and their efforts to undertake person-centred rather than illness-centred therapy. The fact remains that people who have experienced mental illness generally have a negative perception of therapy. There has been a regrettable abuse of the word as in 'electro-convulsive therapy', 'aversion therapy' at one extreme and 'shopping therapy' and 'pet therapy' at the other (Szasz, 1978). The word itself would not enhance our credibility nor make us seem more professional. At present, it would also not ensure that our services become a tax deduction or qualify for health benefits. Rather, it would make people suspicious of our motives. After experiencing our program people might look back and see it as therapy in a positive sense, but initially the

word would have put them off especially for our clients who have a tendency towards paranoia. There is a difference between describing something as therapy and having it prescribed for you (Trowbridge, 1988).

We understand that the concept of therapy being applied during adventure experiences can be useful for some people at some stages and it might be all-important to their wellbeing. However, we think that the essential nature of adventure must be preserved, that it is a state of mind created when a challenging activity is freely chosen, self-directed and intrinsically motivating. People will have adventures when they are taking control of their own lives and becoming more self reliant and interdependent with other people. Therapy can all too often place the person in a passive role.

We feel that in our work we need a term other than adventure therapy. "Psychosocial rehabilitation through adventure" may be accurate but not inspiring. What we try and use is the language of learning, of hope, of personal dignity, of self-determination and of recovery. Our main concern is that we at Out Doors need a term, which does not have medical connotations. For now we talk of rehabilitation, education, recreation and adventure. We listen to participants to find the day to day language that will sustain our credibility with them and hope this will lead to a more appropriate word then adventure therapy.

If this and future adventure therapy conferences lead to the professionalization of adventure therapy, and this means more funding, more services for people who need them, more opportunities for training and better recognition, then we can only welcome that. We believe however that the need for professionalization in what has been called adventure therapy should be questioned. McGill and Hutchison (1992) have clearly outlined the limitations of increased professionalism in an analysis, which is directly relevant to people working in the area of adventure.

We share much common ground with who call what they do "adventure therapy," but our type of service will remain at the boundary areas of this field. We look forward to supportive and open relationships with everyone using adventure as a medium because we need to listen to one of the main demands made by people with mental health needs: that professionals work together to provide continuity of service and a range of choices for people in a way which respects them as the experts in their own lives.

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